CHAPTER 2: NEEDS ASSESSMENT, RESOURCE INVENTORY & GAP ANALYSIS

This Chapter describes the process used by the CPG to assess the met and unmet prevention needs of the priority populations and the barriers in reaching populations. The following sections summarize the needs assessment data sources used, resource inventory and gap analysis results, and summary descriptions of the primary unmet prevention needs.

Key Steps to Conducting A Needs Assessment:

Needs assessment is an essential component of the HIV prevention community planning process. Indicated in Assessing the Need for HIV Prevention Services[1] three steps [components] are essential to conducting a comprehensive needs assessment:

1) Assessing the HIV prevention needs of the populations identified by the epidemiologic profile as being at high risk for HIV infection.

2) Assessing existing community resources for HIV prevention to determine the community's capability to respond to the epidemic, including both resources that are directly HIV-related and other efforts and activities that may favor HIV risk reduction.

3) Conducting a gap analysis by comparing the findings from the needs assessment regarding high-risk populations with findings from the resource inventory about existing services.

The goal of the needs assessment is to investigate both the met and unmet needs of each population selected and identify barriers to reaching them and engaging them in prevention activities. A met need is a required service that is currently being addressed through existing HIV prevention resources that are available to, appropriate for, and accessible to that population as determined through the resource inventory. An unmet need is a required service that is not currently being addressed through existing HIV prevention services and activities, either because no services are currently available or because available services are either inappropriate for, or inaccessible to, the target populations.

Additionally, the assessment of prevention needs furnishes information about the extent to which specific target populations are aware of HIV transmission methods and high-risk behaviors, are engaging in specific high-risk behavior, have been reached by HIV prevention activities, and are likely to participate in HIV prevention activities. The assessment also identifies barriers that make it difficult to reach specific target populations and involve them in HIV prevention initiatives and suggests strategies that may be effective in overcoming these barriers.

Through CDC External and Technical Review, South Carolina was required to complete an updated needs assessment, resource inventory, gap analysis and write an updated Prevention Plan within six months of the year 2000 review process. CDC acknowledged that a comprehensive

[1] Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups, Academy for Educational Development, Center for Community-Based Health Strategies. Funding provided by CDC. 1999.

needs assessment process could not be reasonably completed in this timeframe. South Carolina received technical assistance from AED in accomplishing these tasks. Based on technical assistance received, the Needs Assessment process completed was divided into three phases. The following table summarizes the different phases, tasks to be completed within each phase, and anticipated timeframe.

PHASES	ANTICIPATED TIMEFRAME	TASKS TO BE COMPLETED
Phase I	2001	Phase I of the needs assessment consisted of collecting information regarding the priority populations through secondary data sources; conducting focus groups with two prevention provider groups, and surveying providers to determine the extent to which prevention services were available, accessible and appropriate for the priority populations.
Phase II	2002	Phase II of the needs assessment will focus on obtaining information from the priority target populations through focus groups, surveys, town meetings, interviews, etc.
Phase III	2003	Phase III of the needs assessment will include round table discussions with representatives of the target populations to share results of Phase II assessment and obtain feedback on the meaning of the results, verification and to learn recommendations for prevention strategies.

The following sections describe how each of the three key needs assessment steps were conducted by the CPG during the Phase I process.

1. Assessment of the HIV Prevention Needs of High Risk Populations

Linking the Needs Assessment with the Epidemiologic Profile

During 2001 a Needs Assessment Workgroup was established to complete an intensive review of needs assessment/inventory data. The first step involved reviewing the Epi Profile (Chapter 1) and comparing with the 2000 priority populations to identify any additional populations that should be included in the needs assessment process. Based on review of the Epi Profile data, the Needs Assessment Workgroup determined that in addition to the priority populations established in 2000, African American men who have sex with women should be included. The list of populations is below.

TARGET POPULATIONS for NEEDS ASSESSMENTS
African American Men who have Sex with Men (MSM), Ages 15-44
African American Women who have Sex with Men (WSM), Ages 15-44
White Men who have Sex with Men (MSM), Ages 15-44

African American Male Injection Drug Users (IDU), Ages 20-44
African American Female Injection Drug Users (IDU), Ages 20-44
White Male Injection Drug User (IDU), Ages 20-44
African American Heterosexual Men, Ages 15-44

Additionally, the Workgroup determined that the needs assessment should separate youth from older adults in order to capture information specifically for this subpopulation of most of the priority populations.

Data from the Epi Profile was also used extensively as a source of information for the priority population descriptions.

Selecting the Research Questions

The primary questions selected to be answered, at least in part, with the Phase I needs assessment were:

What are the HIV-related risk behaviors of the target population?

To what extent is the target population receiving prevention services?

What barriers to accessing or using prevention services do members of the target populations experience or perceive?

What strategies or interventions work best with the target populations?

What HIV prevention or related services are available, accessible, and appropriate for this population?

What are the differences among specific subpopulations regarding prevention needs and access issues?

Selecting the Data and Data Collection Methods

The Needs Assessment Workgroup determined that a variety of data sources would be used during Phase I to describe the needs of each priority population in South Carolina. Given the limited time frame available to conduct the needs assessment process, the Workgroup selected the following data/data collection processes.

a) Secondary research for priority populations
   - Review of needs assessment findings from 1995 – present in South Carolina
   - Review of findings and recommendations from HIV prevention, HIV care and supportive services, and syphilis elimination contractual project reports/grant applications

b) Focus groups
   - County alcohol and other drug abuse agency staff
   - County health department Disease Intervention Specialists (partner counseling staff)

c) Provider surveys
d) Epi Profile and on-going surveillance reports/projects

a) Secondary Research Methods Summary

A review of existing needs assessments and findings conducted by HIV prevention providers and other organizations was completed. Information was solicited from local health departments, alcohol and drug abuse agencies, colleges and universities, correctional institutions, HIV care and supportive services providers, community organizations, youth serving agencies, others. Many of the findings included consumer input/responses through focus groups, surveys, etc. Table 1 on page 2.18 in this Chapter summarizes the inventory of secondary research sources used by the Workgroup.

The request for information included summary of findings, target population(s) of focus, and copy of the survey/focus group questions used. Over 20 sources were received and reviewed by the Workgroup. The Needs Assessment Workgroup reviewed the information provided and determined if the needs assessment findings were of sufficient quality and relevance to be considered. Specifically, for each item submitted the Workgroup briefly described:

- Purpose of Needs Assessment
- Methodology
- Brief description of results
- Target Population(s)
- Intervention Type Assessed
- Research Questions Answered/Not Resolved

Secondary research also included staff review of recent HIV/STD prevention and care services quarterly reports, grant narratives, and project evaluation findings.

Use of Data:
The data were used to develop descriptions of barriers, risks, and prevention needs for the priority population profiles in Chapter 3 Priority Populations and Interventions. Several data were consistent with other data sources (project reports/grant narratives, focus groups, epi profile) thus it validated existing perceptions. For example, several data sources across populations indicate that substance use is a behavior associated with HIV risk through sexual activity; therefore, substance users are listed as a subpopulation in the priority population profiles for all populations.

Some data on intervention suggestions were used to augment priority intervention recommendations for certain population profiles, e.g. African American MSM. Finally, the Needs Assessment Workgroup will use the data as a basis for Phase II assessment questions to obtain more focused information on behavior risks, intervention types, and barriers. For example, some high –risk behaviors described for men who have sex with men should be further examined during the Phase II population needs assessment to determine more insights.

Challenges/Limitations:

The primary challenge encountered with this component of the 2001 needs assessment process was the limited time to solicit information, review, analyze and summarize the information. For example, the Needs Assessment Workgroup needs to more closely examine the data according to the priority populations and the stated research questions and catalog more completely what gaps exist by population.

Limitations of the data are typical of secondary research and include varying type, amount and quality of data across each priority population. Some populations and research questions were more completely described, such as African American women and service access issues for HIV infected persons. Others, such as injecting drug users, were not sufficiently described, a challenge recognized for both needs assessment and intervention purposes. However, while the secondary research did not produce as much data on injecting drug and other substance users, the focus group data provided more information.

It is expected that the Phase II and III needs assessment process to be conducted during the two years will address the limitations regarding gaps in insights for priority populations and subpopulations.

b) Focus Groups Methods Summary

Two focus groups were conducted by the Workgroup during 2001. One focus group was with 11 county alcohol and other drug abuse agency staff. The purpose of this focus group was to obtain more insights around met and unmet needs and barriers for injecting drug users and other substance users, particularly crack-cocaine.

The second focus group was with 10 health department disease intervention specialist staff to obtain more insights around prevention needs and barriers with high risk populations, e.g. partners and/or social networks of HIV infected persons and syphilis cases.

Key questions asked for both focus groups were:

- Which of the following populations do you serve?
- What HIV prevention services do you provide?
- What behaviors do your clients engage in that put them at risk for HIV?
- What stands in the way of your clients practicing behaviors that reduce their risk of HIV?
- What helps your clients practice behaviors that reduce their risk of HIV?
- What are some barriers you encounter in attempting to provide HIV prevention services to your clients?

Pages 2.21 – 2.22 in this Chapter summarize the findings of each focus group.

Uses of Data:
Similar to the secondary research data described above, the focus group data were used to develop priority population profiles, validate other needs assessment information, and will provide a basis for developing questions for Phase II assessments. The data also will be used to identify some training /technical assistance needs for substance use and DIS staff.

Challenges/Limitations:
The primary limitation of the focus group information is the insights may not be representative of all providers, and while the populations described were very high risk and included substance users, it did not provide insights from the populations themselves.

As with secondary data, the Phase II assessment with population input will help to overcome these limitations.

c) Provider Surveys Methods Summary

The third component of the Phase I needs assessment was a survey of current prevention services provided in South Carolina. The information from the survey was used to identify the:

- number and type of agencies providing prevention services
- types of prevention services provided
- priority populations served
- barriers in providing prevention services
- perceptions of inadequate service provision by priority population and type of service
- STD/HIV training needs

The Workgroup reviewed provider surveys used by several states and adapted the provider survey instrument used by the Iowa community planning group. The Statewide HIV/AIDS Resources Guide was used to identify potential organizations/agencies to mail surveys. Over 600 surveys were mailed in April 2001. As of this writing, 105 surveys (16%) have been returned. The actual response rate is difficult to estimate as some duplicate surveys may have been mailed to one agency and over 30 were returned as undeliverable. Due to the time constraints it was not possible to conduct follow-up efforts such as reminder cards or telephone interviews.

See pages 2.23 to 2.33 in this Chapter for provider survey results data.

Use of Data
The Provider Survey data were used to assess and describe the prevention services available and accessible for the priority populations. Again, as with the previous needs assessment components above, some data confirmed existing information. For example, a high percentage of responding providers felt that availability of most prevention services for African American MSM are very limited (this population is the current top ranked priority population). Further, 64% felt that group level interventions for African American MSM were very limited, which is the priority intervention for this population. This "gap" data was consistent with the resource inventory information used for gap analysis.

Challenges/Limitations
The primary limitation of the Provider Survey data is the low response rate (16% at this writing). The response was greatest among community- based organizations (29% of the total respondents) and lowest among alcohol and drug agencies (1% of total). As with the secondary

research component, time constraints limited ability to conduct follow-up efforts to increase response rate. Additionally, the data was limited on services/resources available for the CPG's priority populations; thus, the data could not be used to compile a comprehensive resource inventory for conducting gap analysis.

According to AED (*Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups*), a resource inventory should be broadly focused on services beyond HIV prevention and include educational institutions, businesses, crime prevention programs, family planning, etc. South Carolina currently has an electronic database of a broad range of services by county in its "Statewide HIV/AIDS Resources and Information Guide" (SHARING). SHARING is described more fully on page 6.2 of Chapter 6: Linkages to Other Related Services. It is available for viewing at www.scdhec.net/.

To improve the resource inventory for the next planning phase, information on target populations, financial resources, number of clients served annually and specific intervention types could be requested from most organizations listed in SHARING during its updating by telephone interview. This will result in a geographic listing of resources with the information suggested by AED. GIS mapping of the prevention services by type will be done in order to visually summarize met and unmet needs by geographic area and population. This more complete listing and GIS presentation of the data should improve the gap analysis and priority setting during the 2002 – 2004 planning period.

d) Epi Profile and Surveillance Projects

Chapter 1 describes the process used to develop the Epi Profile. The Epi Profile was used to provide basic behavioral risk information for the priority populations from sources such as the Supplemental HIV/AIDS Surveillance survey (SHAS), STD surveillance data, Youth Risk Behavior Survey. In addition, SHAS data provided information on income, employment, insurance status and access to primary care for persons living with HIV.

Staff used data from the on-going Enhanced Pediatric Surveillance Project to describe the effectiveness of perinatal HIV prevention efforts including access to care and preventive treatments.

Page 9.3 in Chapter 9: Surveillance, Research and Evaluation describes the limitations of the surveillance data and recommendations for enhancing.

2) Assessing the Community's HIV Prevention Resources

Resource Inventory

A Resource Inventory was developed in order to conduct a preliminary gap analysis. The following information was used to summarize resources and populations reached (see pages 2.34 – 2.36 of this chapter):

- Estimated 2001 Allocated CDC Funds by HIV Prevention Program Component (page 2.34)
- Estimated Funding Targeting Persons Contacted By HIV Prevention Services By Race (page 2.35)
- Resource Inventory for CDC Funded Health Education Risk Reduction Interventions (primary item used for Gap Analysis) (page 2.36)

Since the 2000 priority interventions are limited to health education/risk reduction, the Resource Inventory for interventions was limited to health education risk reduction interventions, which are provided by HIV prevention collaborations. Also, complete financial resource data was not available on state and other funding sources, so the inventory listed only CDC prevention funds.

The inventory was developed according to the South Carolina priority populations and interventions as defined in the CDC Evaluation Guidance. The inventory lists the estimated amount of health education/risk reduction CDC funding currently used to target the priority populations by intervention type. The number of estimated providers conducting different intervention types per population is also documented. See page 2.36 Resource Inventory for CDC Funded Health Education Risk Reduction Interventions.

The data sources used to prepare the inventory were the CDC process evaluation reports submitted during 2000. The funding amounts were estimated by determining the funding amount per intervention provided multiplied by the total number of interventions per population per intervention. The number of providers conducting intervention types was obtained from the 2000 reports and updated by telephone interview in June 2001.

Challenges/Limitations:

Several limitations were noted around the quality of the data in the inventory used for gap analysis. These include:

1. The most recent data available to document resources by population and intervention type was the calendar year 2000 HIV prevention contractor reports. However, the priority populations and interventions were determined by the CPG in August 2000; therefore, the 2000 collaboration data was based on somewhat different priorities.

2. While training has occurred with collaboration providers (contractors), the definitions of intervention types are evolving. At present, providers define interventions differently which confounded efforts to define gaps.

3. It is acknowledged that this Inventory data does not document the number of persons receiving a service, which would provide more quality information, e.g. the documentation funds and providers listed for African American Men Who Have Sex With Men is considered as intended/targeted services. It is not known how many self-identified African American MSM are actually receiving the services.

4. A large number of providers and funds are documented in the "other" population category. This category needs to be validated with providers to determine if it is limited

to other population categories such as white women, Hispanics, etc. or does it also include "unknown" or a mixture of several population categories. This "Other" category also confounded efforts to define gaps.

These limitations will be addressed during the next planning period by establishing clear, standard definitions of target populations and interventions for all providers to document using the newly developed web-based software (see Chapter 9: Surveillance, Research and Evaluation). Reports will be monitored, analyzed and reviewed with local providers to verify the data and attempt to ensure standardized documentation prior to the next gap analysis. The new reporting system will also provide data on number of persons receiving services and this number will be included in the inventory developed for the next priority setting process.

3) Conducting The Gap Analysis

Based on technical assistance received by AED on conducting gap analysis, the CPG conducted a preliminary gap analysis to determine if the uses of prevention funds were consistent with the priority populations, and if the uses of funds for interventions per population were consistent with priorities. Below are the discussion questions used by the CPG to conduct the preliminary gap analysis.

Population Gap Analysis Questions

1. What does the resource inventory say about current HE/RR efforts to reach these populations?
2. What are the gaps in terms of the populations? What indicator(s) did you use to identify these gaps?
3. Are there any specific reasons/considerations to explain these gaps?
4. What recommendations do you have to address these population gaps?

Intervention Gap Analysis Questions

For each population:
1. What does the resource inventory say about current interventions targeting X population?
2. What are gaps in interventions targeting X population? What indicators did you use to identify these gaps?
3. Are there specific reasons/ considerations to explain these gaps?
4. What recommendations do you have to address these gaps?

The CPG was divided into six groups, one for each of the six priority populations. Using the Resource Inventory of CDC Funded HE/RR Interventions (see page 2.36 of this Chapter), each group responded to the population gap analysis questions above and then responded to the intervention gap analysis questions for their group's respective population. Groups reported back to the full CPG for additional comments/discussion.

Key Conclusions/Findings From The Gap Analysis on Health Education Risk Reduction Interventions:

Below is a summary of the gap analysis discussions determining met and unmet needs for HE/RR services.

Table 1. Comparison of Alignment Between Prioritized Populations and HE/RR Prevention Providers/Resources

POPULATIONS In Rank Order	# OF PROVIDERS	MONEY (CDC-Funds Only)	MONEY/ PROVIDER Ratio
1. AA MSM	46	$ 321,000	$ 6978/each
2. AA WSM	49	$ 343,000	$ 7,000 /each
3. W MSM	26	$ 93,000	$ 3,577/each
4. AA M IDU	30	$ 1,000	$ 33/each
5. AA F IDU	21	$ 3,200	$ 152/each
6. W M IDU	17	$ 1,200	$ 71/each

Note: Shaded Areas in Table Represent Potential Population Gaps

The Table above indicates that the top two ranked populations, African American MSM and African American Women have the greatest proportion of targeted funds and number of providers. Potential gaps are White Men Who Have Sex with Men, and more evident gaps exist for African American Male IDU, Female IDU and White Male IDU populations.

The apparent gap for all injecting drug user populations may be due to their being hard –to-reach populations and/or not self-identifying populations. Additionally, IDU populations are usually targeted by substance abuse agencies, and substance abuse treatment requires a certain expertise that may not be represented by the HIV prevention collaboration membership providers.

Not reflected in Table 1 above are the providers and resources directed to African American men who sex with women and "Other". African American men who sex with women are not a ranked priority population but were added as a population for needs assessment purposes. Forty-five providers conduct interventions for this population for an estimated $126,000. The "Other" category had 60 providers and $296,000 allocated. As discussed previously, the definition of "Other" category needs further exploration with reporting sources as it reflects the third greatest proportion of funds and the greatest number of providers.

Table 2. Comparison of Alignment of Priority Interventions for Populations and HE/RR Prevention Providers/Resources

POPULATION IN RANK ORDER	INTERVENTION PRIORITY (UNRANKED)	Total % of Providers Delivering 1 or More Priority Interventions	Total % of Funds Directed at 1 or More Priority Interventions
African America MSM	Group Level	10%	5%

African American Women (WSM)	Individual Group	20%	14%
White MSM	Group Community	20%	16%
African American Male IDUs	Individual Group Community	47%	32%
African American Female IDUs	Individual Group Community Outreach	53%	93%
White Male IDUs	Group Outreach	42%	43%

*Notes: 1) Gaps: Shaded areas represent both potential population and intervention gaps.
2) Within each population category, providers and resources not directed toward priority interventions are directed for "other " interventions for that respective population.

Based on Table 2 above, there is an apparent potential gap for all priority HE/RR interventions for each population. The majority of funds/providers for each population are targeted for other interventions such as outreach, individual, health communications/public information. A primary reason for this apparent "gap" in interventions is most likely due to the timing of the priority setting (completed in July 2000) yet the data used for the gap analysis resource inventory was the entire 2000 calendar year reports from contractors that did not have time to adjust for the new priorities.

Recommendations to Address Population and Intervention Gaps

As a result of the Gap Analysis process, the CPG identified areas to address in future needs assessments and priority setting, and identified recommendations to address the potential gaps.

Population Gaps

There is a need to further assess the level of resources targeting injecting drug users from other sources. The magnitude of the apparent unmet need reflected with CDC funds may not be as great if other agencies are addressing. To address this, one of the Phase II needs assessment research questions will be "What is the statewide substance abuse system doing to address the needs of injecting drug users?".

Additionally, the CPG acknowledges that surveillance data indicate an apparent decline in the number of new HIV infections diagnosed among injecting drug users (all racial populations).

For the next priority setting process, the DHEC will attempt to validate this apparent trend with seroprevalence surveys among injecting drug users in both community and treatment settings. If the prevalence estimates confirm a declining trend/lower proportion of total HIV cases attributed to IDU risk, the CPG will also re-examine the definition of "disproportionate impact" as a factor for priority setting.

Intervention Gaps

During the next year the CPG will revisit and discuss priority interventions for each population prior to making significant shifts in funds. The priority interventions may not be realistic for some populations. For example, Outreach and Individual Level interventions may be more appropriate for injecting drug users (than Group level) because of the stigma and criminalization of injecting drug use in South Carolina. Similarly, the priority intervention for African American Men Who Have Sex with Men (Group level) needs to be broadened also due to stigma. The CPG acknowledges that for the next priority setting process greater attention needs to given to community norms, values as a factor for selecting priority interventions.

To address these apparent gaps, recommendations for resource shifting/direction include:

- Ensure substance abuse agencies are included in collaborations to address apparent gaps for injecting drug user populations.
- Allocate proportion of new/supplemental funding toward African American Men Who Have Sex With Men, Group Level Interventions.
- Redistribute focus within collaborations to priority interventions, less on Health Communications/Public Information and other categories.
- Commit technical assistance/capacity building efforts to identify other funding sources and assist in developing applications.
- Commit technical assistance/capacity building efforts to provide training to local staff to ensure they have skills to provide priority interventions according to standards of practice.

Summary: How was the Phase I Needs Assessment data used?

The comprehensive needs assessment and resource inventory data described in this Chapter were used by the CPG for the following :

- Describe key unmet needs and prevention challenges for each priority population, and determine target population goals and intervention needs. (Chapter 3: Priority Populations and Interventions)

- Provide basis for reassessing 2001 priority interventions and recommending priority additional/other interventions, e.g. provide community opportunities for HIV testing; provide culturally appropriate community-level prevention marketing in settings targeting

African American men (inclusive of MSM) (Chapter 3: Priority Populations and Interventions)

- Describe met prevention needs for other key prevention components such as HIV counseling and testing, partner counseling, access to STD services, linkage to care and supportive services. (Chapter 5: Coordination and Chapter 6: Linkages)

- Describe challenges related to linking persons to primary and secondary prevention services and develop key recommendations for improving. (Chapter 6: Linkages To Other Related Services)

- Provide foundation for Phase II Needs Assessment activities during next three years focusing more closely on each priority population's prevention needs, in particular African American MSM, HIV infected persons, injecting drug users.

- Provide basis for identifying technical assistance/training needs through the 2001 Provider Survey (Chapter 8: Technical Assistance).

- Provide basis for selecting key research questions for the next 2002 – 2004 planning period (Chapter 9: Surveillance, Research, and Evaluation)

- Provide basis for recommendations to develop behavioral surveillance systems and outcome monitoring to improve planning and evaluation efforts (Chapter 9: Surveillance, Research, and Evaluation)

Summary: What are the Primary Met Comprehensive Prevention Needs in South Carolina?

Based on the Phase I needs assessment and resource inventory information, the CPG has identified broad areas of met needs for populations. It is acknowledged that these are preliminary assessments and more complete information on met needs by population will be obtained during the Phase II and Phase III needs assessment process and enhanced resource inventory developed as described previously. It is also acknowledged that it is difficult to accurately reflect met (and unmet) needs particularly for populations that are hard-to-reach and underserved.

- Resources for HE/RR interventions reflect a greater amount of effort being targeted to the top two priority populations (African American MSM and African American women having sex with men).

- Interventions such as counseling, testing and referral; partner counseling and referral, and STD services are available in each county for all priority populations. It is acknowledged that these interventions are only partially "met" needs as they may not be consistently

accessible; be delivered in convenient, community settings, or fully meet all the prevention needs of clients served.

Summary: What are the Primary Unmet Comprehensive Prevention Needs in South Carolina?

Based on the extensive information used in the Phase I needs assessment, resource inventory and gap analysis, the CPG identified key unmet prevention needs for all HIV prevention interventions. These unmet needs (unranked) are summarized in general below. More specific descriptions for priority populations and subpopulations are described in Chapter 3: Priority Populations and Interventions, and Chapter 6: Linkages.

Both STD/HIV prevention and HIV care services target in particular African Americans, who are disproportionately impacted by these diseases. Many challenges exist, however, that must be addressed to eliminate this health disparity. The overall impact of poverty, substance use, and insurance status contributes both to placing African Americans at risk for acquiring STD's and HIV and to creating challenges in providing prevention and care services. The impact is particularly significant in rural areas of the state where there are fewer prevention and care providers, longer distances to travel for services, and fears of stigma and discrimination.

Issues of confidentiality remain consistent barriers, especially for rural clients. Fear of alienation and rejection if someone in their small town finds out their HIV status are so great that many clients are reluctant to get tested, and if infected with HIV, are forced to live in denial. The fear of being found out prevents clients from seeking services, following up on symptoms, and from asking questions of health care providers. This fear also can be a barrier for drug adherence, challenging clients to prevent others from seeing the medicines in their home or work setting.

Primary barriers and unmet HIV needs that have been identified by both prevention and care providers include the following:

- Scarce human and financial resources challenge the delivery of HIV/STD services. Many STD clinics must turn clients away for same day treatment; HIV care providers do not enough resources to meet client needs.
- Access to the targeted populations is challenged by distrust and wariness of data and medical/public health institutions.
- For African American men who have sex with men, there is a lack of defined, open "community" in which to direct outreach/education services; lack of family acknowledgement and support of sexuality issues reduces access to preventive health services.
- There is no singular HIV prevention program for African American MSM, multiple approaches are needed.
- Time constraints due to large client caseloads create inequities in availability (and quality) of clinic and risk reduction interventions.

- Barriers to being tested include the stigma of going to be tested, fear of clinic staff talking, fear of being seen at a clinic, and of simply not wanting to know if they have HIV disease.
- Lack of statewide opportunities for community delivered STD/HIV screening and outreach services for populations not being reached by "traditional" services.
- Need for easier access to drug treatment and prevention counseling for alcohol/other drug using persons.
- There is a lack of trained staff to provide range of effective interventions particularly to MSM and HIV infected persons.
- There is a lack of credible members of the affected community advocating for HIV prevention and ownership of HIV.
- There is a need to provide information to high risk groups who do not access community (agency) services (unemployed, out of school).
- Need for expanded, targeted peer education programs for youth and young adults, especially those who are gay, lesbian, bisexual, questioning and who are African American.
- Need for increased peer education and skill building for HIV positive persons.

Additionally, there is a need to better integrate and link care and prevention efforts to reduce the risk of transferring HIV to others from those already infected and to increase the number of HIV infected persons who are in a system of care.

Finally, for each of its priority populations, the statewide HIV Prevention Community Planning Group also identified a need for more behavioral risk data, social network information and needs assessment information involving members of the priority populations to better guide decisions for planning, designing interventions and targeting resources.

Key recommendations for addressing these unmet needs are:

- Reach uninfected people at risk at the community level.
- Involve African American community representatives in designing, planning and delivering local prevention initiatives.
- Reach infected people with HIV testing, treatment referrals, and on-going prevention services (including linking persons with substance abuse treatment programs, family planning, STD, mental health or job training, etc. services).
- Provide information to high-risk groups who do not access community/agency services (unemployed, out of school).
- Increase programs targeting men who have sex with men.
- Expand targeted peer education programs for youth and young adults.
- Improve access to drug treatment and prevention counseling for alcohol/other drug using persons.
- Increase number of trained staff to provide range of effective interventions particularly for men who have sex with men and HIV infected.
- Build capacity among community organizations, including the faith community recognizing differences in abilities to deliver services across communities
- Engage other key leaders to address underlying issues causing HIV stigma and health disparities for African Americans.

Summary of Phase I Needs Assessment Limitations and Recommendations for Future Needs Assessments, Resource Inventory and Gap Analysis	
Challenges/Limitations	**Key Recommendations for Phase II and III Needs Assessment to Address**
1. Data from pre-existing studies, focus groups and provider survey not comparable, e.g. "apples and oranges".	1. Identify key stake-holders to develop clusters of information needs to be obtained through standardized questions.
2. Some gaps exist with recent data from "consumers" (priority populations) regarding prevention needs, barriers, social context issues, etc.	2. Phase II will focus on obtaining information from each priority target population through focus groups, surveys, town meetings, interviews, etc. Phase III round table discussions will be conduced with representatives of the target populations to share results of Phase II assessment and obtain feedback on the meaning of the results, verification and to learn recommendations for prevention strategies.
3.Resource inventory is limited to primarily providers funded with CDC funds.	3. Develop broader resource inventory by using SHARING database to improve knowledge of extent of prevention services available to priority populations.
4. CDC-funded HE/RR providers do not have standard definitions of interventions resulting in lack of reliable data on interventions conducted and priority populations receiving interventions.	4. Develop standard definitions, conduct training and periodic reviews of reported data for quality to improve gap analysis process.

Table 1. Inventory of Secondary Research Reviewed for Phase I Needs Assessment Existing Data and Reports

TARGET POPULATION	DATA/REPORT	METHODS USED
Men Who Have Sex With Men	HIV/AIDS Prevention: The Results of Focus Group Involving Gay African American Men, 2000- Trident HIV Prevention Collaboration	Focus Group
	Role of Stigma/Discrimination and HIV: African American Men, 2000- STATE Newspaper/South Carolina African American HIV/AIDS Council	Focus Group
	African American Males Who Have Sex Males Focus Group- Colleton County, 2000- Access Network/HIV Prevention Collaboration	Focus Group
	South Carolina HIV Risk Behavior Survey (MSM Module), 1999- University of South Carolina for the CPG	Survey
	Group Sex in (White) Gay Men: Its Meaning and HIV Prevention Implications, 1998- University of South Carolina College of Nursing	Face-to-Face Interviews
	The Ujima Project, 1998- South Carolina African American HIV/AIDS Council	Funding Application/ Justification of Need
	HIV/AIDS Environmental Assessment and Investment Strategy Report, 1998- SC Primary Care Association	Focus Group and Individual Interviews
Youth	Comprehensive HIV Education Program Progress Report and Health Behavior Survey, 2001- Palmetto Health District, DHEC	Survey
	Youth, Religion and HIV, 2000 – AID Upstate	Survey
	Development/Violence and Juvenile Crime Prevention Plan, 1999- Community Coalition of Horry County	Social Area Analysis (Community Forums, Focus Groups, Key Informant Interviews)

	Adolescent Pregnancy Prevention Collaborative, 1998- Community Coalition of Horry County	Survey/Focus Group
	Focus Groups of Incarcerated or Detained Youth, School Aged Youth, and Alcohol and Other Drug Using Youth (70% African American), 1996- Eastern Carolina HIV /AIDS Prevention Collaboration	Focus Group
Youth con't	Wake Up and Smell The Coffee, 1994- Dr. Bambi Gaddist for the CPG	Focus Group
	Ryan White Title II and IV Grant Reports, 2000/2001	Provider Reports
	Spiritual Activities as a Resistance Resource for Women with Human Immunodeficiency Virus, 2000- University of South Carolina, College of Nursing	Interviews; Focus Groups
	African American Women's Focus Group, 2000- Access Network/HIV Prevention Collaboration	Focus Group
African American Women	Understudied HIV/STD Risk Behaviors Among A Sample of Rural SC Women: A Descriptive Pilot Study, 1999- Center for Survey Research, Indiana University	Survey, Random Telephone
	Results of Women in a Housing Project, 1999- Trident HIV Prevention Collaboration	Focus Group
	Identification of Factors Impacting Personal Level of Susceptibility and Perception of Risk Associated with Contracting HIV/AIDS as Reported by Women Challenged with HIV/AIDS within SC, 1998- Dr. Bambi Gaddist for the CPG	Focus Group
	Community Needs Assessment, 2000/2001- OCAB Community Action Agency	Survey
	Tri-County HIV Prevention Program Participant Survey, 2000- OCAB Community Action Agency	Survey
IDU's/Substance Users	The Association between Substance Abuse and HIV Risk Taking Behaviors, 2000- Thesis using SC High Risk Survey Data	Survey
	Analysis of Variance and Results of 97 AOD Surveys in Two Charleston Pubs, 1999-	Survey

	Trident HIV Prevention Collaboration	
Mixed Populations (African American Men/Women; HIV Infected Persons; Hispanics)	African American HIV/AIDS Program: Prevention Skills Focus Group Guide, 2001- AID Upstate/HIV Prevention Collaboration	Focus Groups
	Status of HIV/AIDS Services for Minority Persons Living with HIV in Two South Carolina Cities: A Summary of Three Discussion Groups, 2000- SCDHEC, Office of Minority Health	Focus Groups (provider and client)
	Heterosexu al African American Males Focus Group, 2000- Access Network/HIV Prevention Group	Focus Group
Mixed Populations con't	Ryan White Title II and HOPWA Reports, 2000/2001	Provider Input/Client Needs Assessment Surveys
	Statewide Assessment of Health Care Needs of Latino/Hispanic Population, 2000- SCDHEC Office of Minority Health	Face-to-Face Interviews
	South Carolina Diabetes Control Program Focus Group Summary Report, 1999- SCDHEC, Diabetes Control Program	Focus Group

FOCUS GROUP SUMMARY

Two focus groups were conducted on March 1 and March 9, 2001 with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) HIV Early Intervention Services Project Coordinators and South Carolina Department of Health and Environmental Control Disease (DHEC) Intervention Specialists (DIS) respectively. These two groups were selected because of their work with hard-to-reach populations.

According to the demographic profile, ten men and eleven males participated in the focus group discussions. Fifteen of the twenty-one participants self identified their race/ethnicity as African American/Black and 5 as Caucasian/White. Ages ranged from 26 to 60 with a mean age of 43.2; the median age is 45.5, and the mode is 47.

When asked how many years have you worked in the HIV field? The majority of the participants (12) had more than five years work experience in the HIV field, and 5 reported less than one year. The remaining three respondents job experience ranged between 1-3 and 4-5 years. Additionally, greater than 5 years work experience in the alcohol and other drugs field was reported by nine persons while six documented less than one year.

Of the 13 public health districts, participants provided prevention services to eleven of the jurisdictions. Appalachia I and Waccamaw Public Health Districts were not represented by any of member of this group.

The focus group guide contained six questions:
1. Which of the following populations do you serve;
2. What HIV prevention services do you provide;
3. What behaviors do your clients engage in that put them at risk for HIV;
4. What stands in the way of your clients practicing behaviors that reduce their risk of HIV;
5. What helps your clients practice behaviors that reduce their risk of HIV; and
6. What are some of the barriers you encounter in attempting to provide HIV prevention services to your clients?

The major themes for each question are recorded below.

1. **Which of the following populations do you serve?**
   Both agencies provided prevention services to the priority populations: African American MSM, African American WSM, White MSM, African Male IDU, White Male IDU, African American Female IDU, and Crack or Cocaine Users.

2. What HIV prevention services do you provide?

- Outreach
- Counseling and Testing
- Health Education/Risk Reduction

3. What behaviors do your clients engage in that put them at risk for HIV?

- Exchange sex for money, drugs, etc.
- Multiple partners
- Use of alcohol and other drugs, especially crack/cocaine use
- Unprotected sex

4. What stands in the way of your clients practicing behaviors that reduce their risk of HIV?

- Unprotected sex especially with primary partner
- Lack of money to meet needs
- Trading sex for money, drugs, etc.
- Drug addiction

5. What helps your clients practice behaviors that reduce their risk of HIV?

- Nonjudgmental attitude of staff
- Consistent condom use
- Trustworthiness of counselors/staff
- Availability of counselors/staff
- Client centered counseling/Harm reduction

6. What are some of the barriers you encounter in attempting to provide HIV prevention services to your clients?

- Lack of funds
- Lack of training/expertise of staff

Provider Survey Results

TABLE 1 Description of agencies responding

Organization Type	#*	(%)*
Community based organization	29	(28.7)
Government social service agency	25	(24.9)
Other	13	(12.9)
Public health agency	12	(11.9)
Community health center	4	(4.0)
Adult/youth corrections	3	(3.0)
College/university/community college	3	(3.0)
Private, for-profit agency	3	(3.0)
Religious institution/ organization	3	(3.0)
Housing/shelter	2	(2.0)
Alcohol and other drugs	2	(1.0)
Drug treatment center	1	(1.0)
Public library	1	(1.0)
TOTAL	**101**	**100**

* These totals do not include respondents who did not indicate their organization type (15=15.7%)

Respondents were asked to choose one organization type to describe their agencies, or indicate such in a space provided. As table one shows, close to a third of all respondents described their agencies as Community Based Organizations (CBOs), closely followed by those describing theirs as a Government Social Service Agency (GSA). Response rate was lower for local public health and alcohol and drug abuse agencies. Most of those 13 (12.9%) who described their agencies as other than those listed described them as either CBOs or GSAs. About 12% described their agencies as Public Health Agencies. No respondent described their agency as Tribal Clinic, Alternative High School, or Migrant Worker Service Provider. About 4% of respondents did not address this issue.

TABLE 2 Number of organizations that chose specific service descriptors by organization type

Organization Type	ASO	HCF	GLBO	WC	FPC	RC	HC	YSA	DAT	CTR	MCH	STD	Other
Adult/youth Corrections	1						0						1
ATOD							0		3				
College/Univ/ Comm college		1					0			1			
CBO	8	1	1			2	0	9	2	4			6
Community Health center		1			1		0			1	1	2	
Gov. social service agency							0	5	3				9
Housing/ Shelter	1						0	1					
Private, for-profit agency						2	0						
Public health agency	1	6			7	1	0			5	3	8	1
Religious Organization							0			1			
Other	1	2		1			0	3	5	4	1	1	3
TOTAL	**12**	**11**	**1**	**1**	**8**	**5**	**0**	**18**	**13**	**16**	**5**	**11**	**20**

KEY:

ASO: AIDS Service Organization	**HC:** Hemophilia Center
HCF: Health Care Facility	**YSA:** Youth Service Agency
GLBO: Gay/Lesbian/Bisexual Service Organization	**DAT:** Drug and Alcohol Treatment Center
WC: Women Center	**CTR:** Counseling, Testing & Referral Services
FPC: Family Planning Center	**MCH:** Maternal/Child Health Clinic
RC: Red Cross	**STD:** Sexually Transmitted Disease Clinic

Respondents were asked to further describe the agencies within each of their of organization types, and they could chose as many as applied to them. Each descriptor was chosen at least one time, with a range of 1-20. Gay/Lesbian/Bisexual Service Organization and "Women Center" were the least chosen, where as "Youth Service Agency" (not including "other") was the most. Other descriptors with relatively high selection frequencies were Counseling, Testing & Referral Services, Youth Service Agency, Drug and Alcohol Treatment Center, AIDS Service Organization, STD Clinic and Health Care Facility.

Other (sub-type), Community Based Organizations and Public Health Agencies were the most diverse in their descriptions of service type(s) provided. Other (descriptor) was chosen 20 times, indicating the in-exhaustive nature of the responses supplied, and a need to further look into these and related issues.

TABLE 3 Type of population served by providers

Population	#*	(%)*
Rural	73	(72.2)
Urban	70	(69.3)
Correctional Facilities	54	(53.5)
Other	9	(09.0)

*These numbers and percentages overlap, hence the # and % totaled >the sum of respondents and 100%.

Table 3 (above) shows a breakdown of how respondents described the geographic locations of the populations they serve, with Rural and Urban being about the most and the same (72% and 69%, respectively). Note that these numbers overlap, as some respondents would indicate more than one of the possible choices, in any given combination. Furthermore, indicating "Correctional Facilities" does not preclude any of the other three categories.

TABLE 4 Estimated percentage of the racial/ethnic background the people served by respondents

Race/ethnicity of clients	Receiving Service From # (%)	Range of Service Received (%)	Average amount of Service Received (%)
African American	92 (87.6)	(7.0 – 99.0)	(58.04)
Caucasian/White	83 (79.0)	(0.2 – 89.0)	(31.7)
Hispanic/Latino	79 (75.0)	(0.0 – 75.0)	(3.5)
Asian American	63 (60.0)	(0.0 – 40.0)	(1.3)
American Indian/Alaska Native	61 (58.0)	(0.0 – 20.0)	(1.1))
Native Hawaiian/Pacific Islander	54 (51.0)	(0.0 – 80.0)	(3.2)

Asked to estimate the racial/ethnic background of the populations they serve, 87% of respondents indicated that they provide services to African Americans, with this population making up an average of 58.4% of the total number of people they serve. The estimated percentage of Africa Americans in respondents' clientele ranged from 7% to 99%. Caucasian/White was the next estimated most served population, with 79% of respondents indicating this population as making up an average of about 38% of the people they serve (range: 2% to 89%). The rest of the racial/ethnic groups made up very minimal proportions of respondents' clientele, with averages ranging from 1.1% (American Indian/Alaska Native) to 3.5% (Hispanic/Latino). This is notwithstanding the fact that considerably high percentages of respondents indicated that they provide services to these populations: 75% to Hispanic/Latino;

60% to Asian Americans; 58% to American Indian/Alaska Native; and 51% to Native Hawaiian/Pacific Islander.

TABLE 5 Population reached by the STD/HIV/AIDS prevention service providers

Population	# of agencies	(%)
General population	60	(57.0)
Persons of a low socioeconomic status (SES)	55	(52.4)
Young adults (ages 19-24)	53	(50.5)
Youth <19 years	51	(48.6)
Women	47	(44.8)
Heterosexuals	44	(41.9)
Substance users	42	(45.7)
Men who have sex with men	37	(35.2)
Pregnant individuals	36	(34.3)
Crack or cocaine users	35	(33.3)
Persons with HIV/AIDS	35	(33.3)
Injection drug users	33	(31.4)
Persons infected with STD's	33	(31.4)
Bisexuals (males and females)	32	(30.5)
Incarcerated individuals	31	(29.5)
Persons trading sex for drugs/money/shelter	28	(26.7)
Homeless individuals	22	(20.9)
Persons who are sex workers (prostitutes)	19	(18.1)
Mentally ill individuals	19	(18.1)
Migrant workers	19	(18.1)
Developmentally disabled persons	15	(14.3)
Medical professionals	13	(12.3)
Visually or hearing impaired individuals	11	(10.5)
Other	6	(5.7)

Table 5 (above) lists the populations reached by respondents whose agencies/organizations provide STD/HIV/AIDS prevention services, with the most reached population being General Population, followed, respectively, by Persons of low SES, Young Adults (ages 19-24), Youth <19 years, Women, Heterosexuals, and Substance Users. Nearly half of agencies reach these populations. The least reached are populations the "Other" category, excluding which, the least reached population will be Visually and Hearing Impaired Individuals. Men who Sex with Men (a CPG priority), Crack or Cocaine Users, Persons with HIV/AIDS, Injection Drug Users (a CPG priority), Bisexuals (males and females), Persons trading sex for drugs/money/shelter, Persons

who are sex workers (prostitutes) are all respectively reached by few agencies (one-third), ranging from 19 to 37 in number.

TABLE 6 Prevention services offered by prevention providers

Activity/Service Offered	#	(%)
STD/HIV/AIDS education materials	57	(54.3)
Safer sex skills-building groups or workshops	43	(40.9)
Individual risk reduction counseling and education	40	(38.1)
Condom contribution	38	(36.2)
Peer education programs	34	(32.4)
HIV referrals	33	(31.4)
School-based education	27	(25.7)
Community level interventions	27	(25.7)
Sessions targeting those in alcohol and/or other drug treatment	26	(24.8)
On-site HIV counseling, testing and referral	25	(23.8)
Group level interventions	23	(21.9)
Outreach HIV counseling, testing and referral	22	(20.9)
Capacity building	22	(20.9)
Street outreach	20	(19.0)
Volunteer partner counseling and referral	19	(18.1)
Media campaigns	18	(17.1)
Telephone information counseling	18	(17.1)
HIV prevention case management	15	(14.3)
STD screening and treatment	15	(14.3)
Multi-session support groups	14	(13.3)
Other	12	(11.4)
HIV-positive multi-session support groups	11	(10.5)
Needle exchange	1	(0.9)

Table 6 (above) list respondents' indication of the types of services their agencies/organizations provide, ranked here from most provided (STD/HIV/AIDS education services: 54.3%), to least provided (Needle exchange: less than 1%). About one-third of providers offer safer sex skills-building workgroups, individual-level education, condom distribution and peer education.

TABLE 7 Barriers/difficulties in providing STD/HIV Prevention and Care Services

Barriers	#	(%)
Limited funding	71	(70.3)
Limited staffing	62	(61.4)
Target population not aware of services	34	(33.7)
Accessibility of services for the target population	29	(28.7)
Insufficient coordination/collaboration among providers	27	(26.7)
Lack of bilingual staff	26	(25.7)
Lack of African American culturally specific materials	23	(22.8)
Lack of Hispanic/Latino culturally specific materials	17	(16.8)
Clinic hours convenience for clients served	16	(15.8)
Staff retention	16	(15.8)
Other	16	(15.8)
Lack of Native American/Alaska Native specific materials	10	(9.90)
Small size of target population	9	(9.10)
Lack of Asian-American culturally specific materials	9	(8.90)
Lack of Native Hawaiian/Pacific Islander specific materials	7	(0.07)

Table 7 (above) lists barriers/difficulties to providing STD/HIV Prevention and Care Services, as indicated by respondents. 70.3% indicated Limited Funding as a significant barrier/difficulty, followed by Limited Staffing (about 61%). Target population not aware of services (33.7), and Accessibility of Services for the target population (28.7%) were the barriers/difficulties next listed by most respondents, both of which are target population specific. Being a jurisdiction of HIV Prevention Collaborative efforts, it is especially worth noting that 26.7% of respondents indicated insufficient coordination/collaboration among providers as a significant barrier/difficulty.

TABLE 8 Accessibility to STD/HIV/AIDS prevention care and services

Accessibility features	Very Accessible		Moderately Accessible		Not Accessible		Does Not Apply	
	#	%*	#	%*	#	%*	#	%*
Parking	43	*44.8*	23	*24.0*	2	*2.1*	28	*29.2*
Proximity to public transportation	21	*22.6*	15	*16.1*	19	*20.4*	38	*40.9*
Transportation tokens provided	1	*1.1*	9	*9.6*	12	*12.8*	72	*76.6*
Handicapped parking	38	*42.2*	22	*24.4*	3	*3.3*	27	*30.0*
Proximity to target population	30	*32.3*	41	*44.1*	4	*4.3*	18	*19.4*
Proximity to agencies where clients are referred	32	*33.7*	40	*42.1*	3	*3.2*	20	*21.1*
Proximity to hospitals/clinics used by clients	32	*34.0*	40	*42.6*	3	*3.2*	19	*20.2*
Child care	13	*14.0*	11	*11.8*	22	*33.7*	47	*50.5*
Non-English language interpreter	8	*8.4*	29	*30.5*	27	*28.4*	31	*32.6*
Sign language	-	-	21	*22.6*	35	*37.6*	37	*39.8*
Staff representative of target population	28	*29.8*	34	*36.2*	10	*10.6*	22	*23.4*
Total	**246**	***262.9***	**285**	***304***	**140**	***159.6***	**359**	***383.7***
Average accessibility to all services	**23**	***(24)***	**26**	***(28)***	**13**	***(15)***	**33**	***(31)***

*Percentage of total respondents who addressed this question only.

Table 8 (above) is a listing of respondents' estimated ratings of how accessible their agencies'/organizations' services were to clients. On the average, most (31%) of respondents who addressed this question indicated accessibility does not apply to the features listed, where as 28% indicated that these features were accessible, and 24% felt the features were generally very accessible. Specifically, Parking (including Handicapped Parking) was listed as the most accessible feature, ranging from 38% to about 45% or respondents. Proximity to target population, Proximity to agencies where clients are referred, and Proximity to hospitals/clinics used by clients were felt to be moderately accessible by about 43% of respondents. Transportation Tokens Provided, Child Care, Proximity to Public Transportation, Sign Language, and Non-English language interpreter were, respectively, listed most as Does Not Apply. Sign language, Child care, Non-English language interpreter, and Proximity to public transportation were respectively listed as Not Accessible by between 20.4% and 37% of all respondents addressing this question.

Table 9 (below) summarizes respondents' assessment of how well services are provided to selected populations in their area of service. Listed are percentages of respondents who did not feel the service in question was provided at all, and/or felt the service was somewhat provided, but not in sufficient quantity to meet demand. The shaded cells under each population represent the CPG's 2001 priority interventions.

Table 9 Inadequate provision of HIV prevention services for selected populations

Type of service	AA MSM	White MSM	AA WSM	AA MSW	AA Male IDU	AA Female IDU	White Male IDU	Crack or cocaine users
	(Percentage of respondents addressing this question who did not feel the service was provided at all, or felt the service was somewhat provided, but not in sufficient quantity to meet demand)							
HIV Prevention Services for Individuals: Health education and risk reduction for individuals: helping clients make plans for behavior change; providing referrals for service	63.1	58.8	42.4	39.5	60.5	60.5	60.5	64.0
HIV Counseling, Testing, Referral and Partner Notification: Services that provide confidential client-centered opportunities for individuals to learn their serostatus and receive prevention counseling and referral	49.4	48.8	42.9	44.7	52.9	52.9	52.9	57.6
HIV Prevention Services for Groups: Health education and risk reduction education for groups, or individuals, includes informational and skill-building programs	64.0	60.7	43.5	45.3	61.2	62.4	62.4	68.2
Community Level Interventions: Programs that target the selected community, involves community members in the design and delivery and attempts to change community norms and individual behaviors	73.8	67.4	62.4	61.1	72.9	72.9	70.6	78.8
Public Information Programs: Services that aid to dispel myths about HIV transmission, support volunteerism for prevention programs, reduce discrimination toward individuals with HIV/AIDS and promote support for strategies/ interventions that contribute to prevention in the community	66.7	65.1	52.3	51.7	65.1	65.1	66.3	72.1
HIV Prevention Capacity Building: Services that strengthen public health infrastructure in support of HIV prevention, implementing systems to ensure quality of services delivered and improving the ability to assess community needs and provide technical assistance in all aspects of program planning and operations	75.9	69.4	65.1	65.5	77.9	76.7	76.5	83.7
Outreach: Education generally conducted face-face with high risk individuals in the clients' neighborhoods: distribution of condoms, bleach, sexuality responsibility kits and educational materials. Includes peer opinion leader models	76.5	74.7	62.4	64.0	71.8	72.1	74.4	74.4
Prevention Case Management: Client-centered activity with goal of promoting the adoption of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs: a hybrid of HIV risk reduction counseling and traditional case management that provides intensive ongoing and individualized prevention counseling, support and service brokerage.	67.9	61.0	55.5	58.3	68.7	67.5	68.3	72.3

Table 10 STD/HIV/AIDS Training needs for staff for volunteers

Topic	Training Need: YES		Make staff available for training: YES	
	#	(%*)	#	(%*)
Program development	46	(45.5)	44	(97.6)
Knowledge of effective intervention strategies	50	(49.5)	48	(96.0)
How to work with the media	36	(35.6)	35	(97.2)
Program evaluation	39	(38.6)	38	(97.4)
Culturally sensitive programs	46	(45.5)	44	(95.6)
Risk reduction/behavior change	46	(45.5)	44	(95.6)
Counseling and testing	35	(34.6)	34	(97.1)
HIV+ speakers	40	(39.6)	36	(90.0)
Human sexuality	37	(36.6)	34	(91.9)
HIV/AIDS update	52	(51.5)	49	(94.20
Behavioral theory	37	(36.6)	34	(91.9)
Providing services to hard to reach populations	49	48.5	47	(95.9)
Other	02	(02.0)	-	-
Average Total Training Need	43	(42.5)	41	93.3

*Percentage of respondents who addressed this question (n=101)

Training and Other Unmet Needs

Table 10 is a listing of the training needs, as well as a rating of willingness to make staff available for the training in question if it were provided, of staff and volunteers of agencies whose respondents addressed this question. On the average (excluding "Other"), 42.5% of all respondents who addressed this question indicated a training need for all the topics listed, and an average of 93.3% indicated that they would make staff available for training if such training were provided.

Table 11 Number and percentage of respondents by district

Health District	#*	(%)*
Palmetto	15	(14.8)
Upper Savannah	13	(12.9)
Appalachia II	12	(11.9)
Catawba	12	(11.9)
Wateree	12	(11.9)
Appalachia III	11	(10.9)
Trident	10	(9.9)
Edisto	9	(8.9)
Pee Dee	9	(8.9)
Lower Savannah	7	(6.9)
Low Country	7	(6.9)
Waccamaw	6	(5.9)
Appalachia I	4	(3.9)
Total*	127 by 13 Districts	-

*Some of these numbers overlap, corresponding to respondents who reported serving in areas spanning more than one health district, and the responses here relate only to those respondents who addressed this question.

Table 11 is a grouping of respondents by SC public health district, with Palmetto Health District Counties being listed by most respondents (15) as the area which best describes the geographic area their agency/organization primarily serves, followed by Upper Savannah, and Appalachia II, Catawba, and Wateree. Appalachia I counties were least listed under this category.

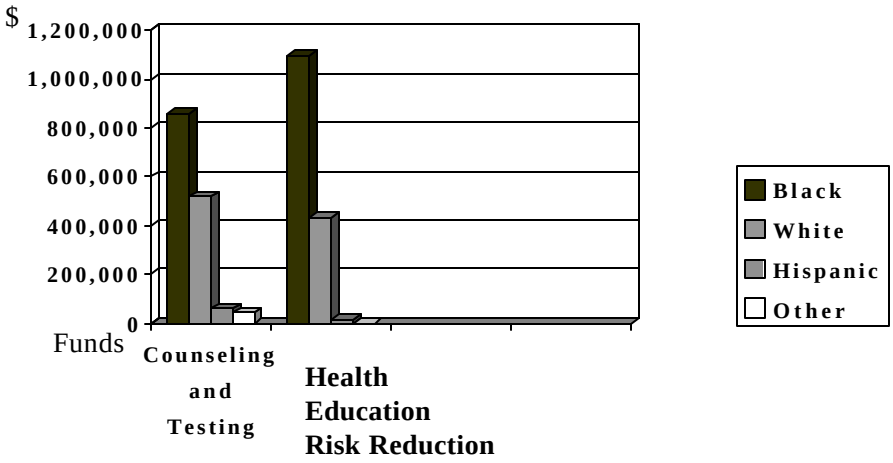
RESOURCE INVENTORY/GAP ANALYSIS DATA

Estimated 2001 Allocated Amounts by HIV Prevention Program Component

Essential Program Component	*Estimated Allocated Amount*	*2001 Supplemental*	*Total*
Counseling, Testing, Referral, Partner Counseling	**$1, 476,583 (DHEC/Collab.)**	**$60,200 (community)**	**$1,536,783**
Health Education/Risk Reduction	**$1, 541,620 [Prevention Case Management – $497,077 Other Health Education/RR- $1,044,543]**	**$351,285 (may include some community delivered C&T for HIV infected persons)**	**$1,892,905**
Public Information	**$199,956**	**$40,000**	**$239,956**
Evaluation	**$174,107**	**$33,388**	**$207,495**
Capacity Building	**$125,912**	**$17,600**	**$143,512**
Community Planning	**$194,230**	**$27,050**	**$221,280**
Other	**$254,292**	**$3,510**	**$257,802**
Indirect Cost	**$160,103**	**$6,840**	**$166,943**
Total Amount	**$4,126,803**	**$539,873**	**$4,666,676**

Note: Excludes additional $62,306 for 2001 perinatal prevention supplement

Estimated Funding Targeting Persons Contacted by HIV Prevention Services, By Race



SCDHEC- local health dept. and collaboration services, 2000 estimate

RESOURCE INVENTORY OF CDC-FUNDED HE/RR INTERVENTIONS

PRIORITY POPULATION	INTERVENTIONS	NUMBER OF PROVIDERS	CURRENT FUNDING*	GAPS Y=yes N= no
African American MSM** ***Total***	Group (GLI)**	4	$ 13,915	
	Other – Outreach, HC/PI, ILI, CLI,C&T	*42*	*$306,773*	
		46	**$320,688**	
African American WSM (Heterosexual)	Individual (ILI)	1	$ 9,528	
	Group (GLI)	9	$ 37,319	
	Other – Outreach, HC/PI, ILI,CLI, C&T	*39*	*$ 296,320*	
Total		49	**$ 343,167**	
White MSM ***Total***	Group (GLI)	2	$ 11,642	
	Community (CLI	3	$ 2,722	
	Other – Outreach, HC/PI, CLI, C&T	*21*	*$ 78,378*	
		26	**$ 92,742**	
African American Male IDU ***Total***	Individual (ILI)	2	$ 317	
	Group (GLI)	12	0	
	Community (CLI)	0	0	
	Other-Outreach	16	*$ 687*	
		30	**$ 1,004**	
African American Female IDU *Total*	Individual (ILI)	2	$ 2,035	
	Group (GLI)	3	0	
	Community (CLI)	0	0	
	Outreach	6	$ 1,018	
	Other-HCPI, C&T	*10*	*$ 225*	
		21	**$ 3,277**	
White Male IDU *Total*	Group (GLI)	3	0	
	Outreach	4	$ 515	
	Other – ILI,OR, HCPI, C&T	*10*	*$ 674*	
		17	**$ 1,189**	
African American MSW (heterosexual)	*3ILI; 5GLI, 6CLI; 7OR;11HCPI; 5C&T; 8 other*	45	**$126,217**	
Total $$s for Prioritized Pop.			**$888,284**	
Other Pop. – MSM/IDU, White Females, White MSW, Other M & F		60	$296,201	
Total $$s for HE/RR			**$1,184,485**	

NOTES:

*This amount is based on taking the Total Collaboration 2001 funding divided by the total number of interventions reported by the Collaborations during 2000 which equals a dollar amount per intervention. Then the dollar amount per intervention is multiplied by the number of total interventions for that population by type of intervention. $1,184,502 is allocated to Collaborations for interventions and a total estimated number of activities reported in 2000 of 89,632 interventions. $1,184,502 divided by 89,632 = $13.215 per intervention.

Number of Providers is based on 2001 Collaboration reports

**Abbreviations:

Populations
AA=African American
W= White
MSM = Men Who Have Sex with Men
WSM = Women Who Have Sex with Men
MSW = Men Who Have Sex With Women
IDU = Injecting Drug User
M=Male
F=Female

CDC Defined Intervention Types
ILI=Individual Level Intervention
GLI = Group Level Intervention
CLI = Community Level Interventions
HC/PI = Health Communication/Public Information
PCM=Prevention Case Management
PCRS = Partner Counseling & Referral Services
C & T = Counseling, Testing (and Referral) Services